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Clinton Ignores His Own Commission in Pursuit of Healthcare Mandates

GAO Underscores Folly of Legislating Excessive Healthcare Mandates

Two new reports from the General Accounting Office (GAO), Congress' nonpartisan investigative agency, help underscore the wisdom behind the President's advisory commission on healthcare quality (otherwise known as the "Quality Commission") in *not* recommending that efforts to improve healthcare quality be legislated.

One report — dealing with review for health claims denials — suggests Clinton's (and Senator Kennedy's) efforts in this arena amount to imposing macro-solutions to micro-problems. The other report — on requiring consumer information — shows the Commission's plans as a mandate would run rough-shod over continuing private-sector attempts to devise meaningful, workable solutions without the heavy hand of government.

Yet the President is ignoring his own commission in that while it does *not* call for the recommendations to be turned into legislative mandates, *he does*. (And he doesn't even stop there: he goes even further by also calling for an unprecedented expansion of liability that likely will result in a slew of additional lawsuits against both insurers and purchasers, i.e., employers — only adding to everyone's costs, and ultimately leading to more and more employers dropping coverage for their employees.)

Likely Result: Diversion of Resources from Where They're Best Utilized

The GAO recently released two reports commissioned by Senators Craig, Coverdell, and Roth to study two of the most prominent Quality Commission proposals: expanded review of denied claims, and increased information dissemination to consumers. The questions the astute consumer will want to ask, in light of the GAO conclusions, are these: Are mandates necessary; and, if all of these requirements are mandated, will implementing them result in scarce health care resources being diverted from where they are most needed?

In the denied-claims study, GAO examined Medicare's claims process in its optional managed care program. GAO found that Medicare's managed care program is using an appeal process similar to that recommended by the Quality Commission, with the key distinction being that Medicare's process is even more extensive than the Commission's recommendations. Yet, in spite of the extensive nature of the Medicare claims review process, *fewer than one-half of one percent* of claims made it to the external review stage. This is remarkable when one notes that, under Medicare, "virtually all internal appeals that are not *completely* favorable to the beneficiary are *automatically* subject to Medicare's external review process." Yet, despite this liberal review process, in 1997 the external review process resulted in upholding Medicare's denial in fully 69 percent of the cases. Only 23 percent of externally reviewed denials were either overturned or partially overturned.

In the case of consumer information, GAO looked at existing practices in the private sector and in the federal employees' health plan (FEHBP). GAO found that mandating the Quality Commission's requirements would exceed so-called best practices in the private sector (that is, those offered by very large employers that offer a choice of health plans, and that have "reputations as innovators in the health care purchasing arena"). It also found, interestingly, that the best private-sector practices on information availability offered about twice that of what the federal government was requiring to be available for its own employees. [While the President has since mandated government healthcare purchasers and providers to adopt the Commission's recommendations, no evidence is yet available as to how, or even if, this will be successful.]

In summation, the GAO's studies show that on the issue of increased consumer information, many of the recommendations are already in place and expanding in the private sector, and in the case of claims denials, the solution may be bigger than the problem, based on Medicare's external review history. Those revelations, coupled with the President's disregard of his own Commission's recommendations, raises the question of motives. Is this ClintonCare revisited? Recall the President's candid remarks last September, when he told a supportive group, "If what I tried before won't work, maybe we can do it another way. That's what we've tried to do, a step at a time until eventually we finish this."

The President's Quality Commission

On September 5, 1996, the President created the Advisory Commission on Consumer Protection and Quality in the Health Care Industry — the "Quality Commission." Its mission was to "advise the President on changes occurring in the health care system and recommend such measures as may be necessary to promote and assure health care quality and value, and protect consumers and workers in the health care system." The Commission was not created to recommend legislation. Members were appointed in March, 1997 and the Commission issued its preliminary report last November, and its final report in March of this year. The Commission made recommendations in eight areas, including procedures for reviewing denied claims and for increasing consumer information.

Neither the preliminary report nor the final report recommended legislation. HHS Secretary Donna Shalala, co-chair of the Commission, at the time the preliminary report was issued acknowledged that the Commission's work did not need to be legislatively implemented. The *New York Times* on March 13 reporting on the Commission's final report, stated, "In a setback for the White House, a Presidential advisory commission declined today to endorse the use of legislation...the panel agreed without dissent on the need for a renewed commitment to improving the quality of health care in America. But it left open the possibility that voluntary efforts could achieve the goal without new Federal laws."

However, President Clinton did not wait for the final report, but acted simultaneously with the release of the recommendations in the preliminary report last fall, calling on Congress to "make them the law of the land." He furthermore expanded the Commission's recommendations by espousing expanded litigation between consumers, their employers and their health plans. [This proposal will be the subject of a separate RPC paper.]

Review for Insurers' Claims Denials: Macro-solutions to Micro-problems

GAO was commissioned to compare the Quality Commission's recommendations with those of Medicare's existing review practices. GAO noted the Quality Commission recommended an appeal process that is "very similar in structure to the process used by the Medicare managed care program" [GAO/HEHS-98-155R, 5/8/98] and this has been in place for a number of years.

In two important ways, the Medicare review process is a more rigorous test than that called for by the Commission. The most significant difference is that "virtually all internal appeals that are not completely favorable to the beneficiary are automatically subject to Medicare's external review process, while the Quality Commission restricts external review to appeals that involve experimental issues, circumstances that jeopardize the health or life of the patient, or services that exceed a significant financial threshold that has remained unspecified." (GAO noted one Commission representative told them the Commission "did not want the time and resources involved in conducting an external appeal to be used for relatively minor or inexpensive services... The Quality Commission did not define significant threshold, although amounts ranging from $100 to $5,000 were considered." Further, the Quality Commission's report stated that enrollees could not use the external process for services that were specifically excluded from their insurance coverage as established by contract, such as cosmetic surgery.

Another significant distinction noted by GAO was that the private-sector population, "which generally is healthier and uses fewer services than Medicare enrollees, may also have fewer appeals per capita."

Despite the fact that Medicare's claims review system is more extensive than that recommended by the Commission for the private sector, GAO reached some interesting conclusions.

- A private-sector appeals process already exists in many commercial managed care plans, most in the form of an internal process for reviewing appeals, which GAO recognized as an important element in the process. If the Medicare sample could be applied exactly to the private-care scenario, we'd see less than one-half of one percent of claims go beyond this stage.

- With the exception of 1994, the Medicare claims review process has upheld the plan denials in 50 percent or more of its decisions each year. GAO notes an upward trend in the denials upheld: in 1997, it was 69 percent of the plan denials. Between 1990 and 1997, the rates of denials being overturned (including partially overturned) decreased from 34 percent to 23 percent.

- Of the 572 appeals that GAO examined, just 14.5 percent (83 cases) of the cases were overturned based on "clinical considerations" (that is, the dispute was over whether the service was medically necessary and also met all of Medicare's clinical coverage criteria). Many of the other cases (both those overturned and those upheld) were based on procedural reasons, that is on the question of whether rules were properly followed. (Note also, that with regard to the claims overturned for "clinical reasons," many of these involved the issue of Skilled Nursing Facility care, an area of coverage that will be a minor issue at most in the non-elderly population.)

- In the area of emergency room visits, one category of Medicare appeals that would translate into a private sector concern, these appeals amounted to just 4 percent in 1997 — or eight thousandths of one percent of the total Medicare claims.

- In 1996, GAO found the dollar value of services that the Medicare review system overturned to be about $3 million." That has to be considered an insignificant number in a Medicare system that cost $190 billion in 1997, and in which fully 14 percent of Medicare's 38 million beneficiaries are enrolled in the managed care plan.

In short, GAO found appeal procedures already in place in the private sector, and in their review of the expansive appeal procedure established by Medicare — one far more expansive than recommended by the Quality Commission — external appeals occurred in "fewer than three-tenths of one percent" of the caseload. These appeals amounted to just $3 million in 1996 and less than one in five of the reviewed cases were overturned based on "clinical considerations."

The GAO on Consumer Information: When Do Costs Outweigh Benefits?

In a separate study, GAO reviewed the Commission's recommendations regarding consumer information and compared it to the information currently being provided to employees of large public and private healthcare purchasers. GAO found that the private sector is already reporting much of what consumers find useful and that the private sector was ahead of the federal government on meeting the Commission's consumer-information recommendations. Specifically, the large purchasers and their associated health plans, in GAO's review, currently provide "over half the data

elements the Commission recommended be routinely provided to customers." In fact, the private employers provide 15 of the 31 specified criteria GAO identified from the Quality Commission's recommendations, as compared to just 8 criteria provided by the federal employees' health care system. (One should reflect that if the most innovative purchasers of health care have decided that they cannot efficiently provide more detailed information, how will smaller employers be able to do so?) GAO estimates meeting the Consumer Bill of Rights information disclosure recommendations would add $0.59 to $2.17 per enrollee per month to current information-related expenses. (That additional cost may well make a difference to smaller employers whose decisions to offer health care benefits are based on tight operating margins. Only they know at what point the costs outweigh the benefits of continuing to provide coverage to their employees.)

Private Sector is Already Developing Information Consumers Want

- The GAO study notes the private sector already has developed an extensive set of data to help purchasers get the greatest value for their health care dollars. The product is known as the Health Plan Employer Data and Information Set (HEDIS), and it currently includes 86 reporting and testing measures in eight areas. In fact, the federal government already takes advantage of this private-sector tool by urging HMOs to participate in it, and more than 90 percent of them do.

- According to GAO, another private-sector source of information for consumers are the nonprofit accrediting entities. One of them, the National Committee for Quality Assurance, alone has reviewed more than half of the nation's HMOs, which account for some 75 percent of all Americans enrolled in HMOs.

- Without government intervention, says GAO, most of the healthcare purchasers studied indicated that they intend to continue expanding their information development and disclosure efforts.

A Question if Consumers Want Additional Information and the Feasibility of Providing It

- The Commission's recommendations present a real possibility of information overload and a possible waste of valuable resources. GAO found that many enrollees do not use the health care information currently made available to them, in part because it may be difficult to understand. "Among the information that purchasers provide, consumers find details on cost, benefits, and the availability of providers most useful; performance measures are more difficult to understand and, as a result, may be used less often."

- The GAO report acknowledges that while employees have access to a considerable amount of information on health plans, the information is more limited about health professionals and facilities. A variety of reasons were suggested, including the assertion by one manager that such quality indicators "do not exist" and likely are several years away from being available. That assessment is echoed by a private analysis GAO reviewed that notes that the most expensive component of information disclosure is obtaining quality and satisfactory information regarding individual physicians "largely because of the sheer number of physicians and the labor intensity of collecting the information." However, many large

purchasers have compiled and reported to their employees comparative information on plan characteristics and performance, including enrollee satisfaction.

- The GAO report concludes with a question mark on the ability of healthcare consumers to benefit from more mandated information. As just one caveat, the report notes that surveys show that in choosing a health plan, "consumers say that quality of care is their greatest concern, but they ultimately make their decisions on the basis of personal recommendations rather than quality data." Another survey showed three-quarters of respondents said they would choose to see a surgeon they knew instead of one they didn't know but who had much higher ratings.

- Another concern GAO raised that Clinton and Kennedy gloss over was the revelation that some information is too technical to be translated into a readily understandable or legible explanation. Yet, the Commission would have such information provided, despite the amount of information already apparently rejected by consumers due to its lack of clarity.

- Some private purchasers are seeking improvement in the standardization and quality of data. And, GAO found the private sector purchasers they surveyed are continuing to work to improve the healthcare information they can provide to their employees. An organization of more than 100 large employers, for example, is working to assure consistency in data collection and dissemination. Purchasers are also working with plan providers to improve the quality and reliability of data they can get from health plans.

More Unnecessary Mandates are Not the Right Prescription

Meanwhile, President Clinton and Senator Kennedy, just can't seem to quit practicing medicine without a license. They are once again prescribing a whole host of excessive remedies for problems that either may not exist or that patients and their doctors are already successfully addressing without bureaucrats and barristers barnstorming the operating room. In pushing legislation at what they see to be a problem, Clinton and Kennedy are ignoring the Quality Commission's recognition that legislation isn't the cure-all, yet they use the Commission's findings as a surgical mask for cover.

As GAO's two recent reports demonstrate, additional government regulations must be carefully applied, if at all, if they are not to cause harm. Requiring private health care to divert scarce resources — doctors, dollars, and days — to address the limitless whims of politicians and bureaucrats means that there will be less resources available for the legitimate needs of patients. Following the collapse of their plan to nationalize America's health care four years ago, it becomes more and more obvious that Clinton and Kennedy are more interested in finding a problem for their solution than they are in improving health care.

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